Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 6, 2016	2016_199626_0009	006279-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

FOSTERBROOKE
330 KING STREET WEST NEWCASTLE ON L1B 1G9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DENISE BROWN (626), LYNDA BROWN (111), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 14, 15, 16, 17, 18, 21 and 22, 2016

The following were inspected during the course of the Resident Quality Inspection:

Complaint log #026961-15 regarding an inquiry about bringing a hospital bed into the home.

Critical Incident log #2625-000007-15, Intake log #014910-15; Critical Incident log #2625-000010-16, Intake log #007991-16 and Critical Incident log #265-000009-16, Intake log #007999-16 all pertaining to an alleged staff to resident abuse/neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Environmental Service Manager, Wound Care Nurse, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, Physiotherapist, Resident Council Leadership Team Member, Family Council President and Family Members.

Also completed during the inspection, the Inspector (s), toured the resident home areas, and observed staff to resident provision of care, dining service, infection control practices and medication administration. The Inspector(s) reviewed residents clinical health records, internal abuse investigations, staff education records, maintenance records, applicable policies, resident and family council minutes, admission process, complaints and critical incidents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, O. Reg. 79/10, s. 12 (2) (e) by not ensuring that a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so.

A specified room was observed during stage 1 of the RQI to not have a comfortable easy chair:

-Where resident #029 resides is a 4 bed room and had no comfortable easy chairs available.
- Interview of resident #029 stated to inspector "there is no chair in the room to sit".

The home was issued non-compliance during the RQI on February 20, 2014 for O.Reg. 79/10, s.12 (2) (e).

Interview of the Executive Director (ED) indicated awareness of previous non-compliance related to lack of comfortable chairs in resident rooms. The Executive Director indicated the home purchases 10 new chairs per year and some times staff removes the chairs out of the resident rooms to the lounges due to a lack of space and safety concerns. The Executive Director indicated there should be at least one chair in each room but there is no process in place to ensure that when chairs are removed (by staff) from the resident rooms for procedures that the chairs are returned. [s. 12. (2) (e)] (111)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a comfortable easy chair is provided for resident # 029 in the resident's bedroom, or an comfortable easy chair is made available when the need arises, with the understanding that the chair may be moved from time to time in response to safety concerns linked to restricted space. The home shall establish a plan to ensure that a consistent process is in place, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2)(c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the dates of this inspection:

Walls: Black marks on wall in second floor hallway next to room 203 and on first floor hallway next to room 111; in room 119, scraped paint and peeling drywall under window and above baseboard, chipped drywall and two small holes behind toilet in bathroom; in room 109, cracks in wall tiles over the sink in the bathroom; missing piece of baseboard (about 50 cm long) from wall next to door of room 103.

Floors: In room 108, small tear on the linoleum on the floor at the entrance to the bathroom; caulking around toilet base is missing in bathroom of room 219.

Doors and Door Frames: Plastic door frame guards are damaged from lower corners in rooms 109, 110, 119, 201, 204, 211, 212 and bathroom door frame of room 116; Chipped lower bathroom door with wood exposed in room 119 and 212.

Privacy Curtains: Privacy curtains are torn from the top (about 15 cm tear) in room 204 and 101.

Tub Room (first floor): Cracked floor on multiple areas between tub and shower area and at entrance of the tub room; cracked and missing two tiles above toilet seat tank.

Tub Room (second floor): Loose baseboard next to shower area (water may seep in).

Baseboard Heaters: In room 119, one of the baseboard heaters was missing the cover and the internal structure was exposed; in room 204, the cover on heater was lifted in the middle creating a sharp angle in the middle under window; scraped paint on baseboard heater in rooms 109 and 204.

Staff interviewed indicated to the inspector that the needed repairs are communicated to the Environmental Services Manager (ESM) verbally and by completing the online maintenance request form.

A review of the home's electronic maintenance requests logs for the period of February 16, 2016 to March 18, 2016, failed to provide documentation that repairs noted above by the inspector(s) were identified as needing repairs.

Interview with the ESM indicated to the inspector that any needed repairs in the home are communicated to him using the online Maintenance Care program accessible by majority of staff in the home. This program is checked daily and any needed repairs are done depending on the priority of the repair issue. The ESM indicated to the inspector that the tub room in the first floor is scheduled for renovation this year. The ESM indicated no awareness of any torn privacy curtains and the extent of damages to door frames guards.

Not maintaining the home, furnishings and equipment in a safe condition and a good state of repair presents potential risks to the health, comfort, safety and well-being of residents. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 8 (1) (b), by not ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to skin and wound care.

Under O. Reg. 79/10, s.48(1)2 every licensee of a long-term care home shall ensure that the following interdisciplinary program is developed and implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Review of the licensee's Skin and Wound Program policy #LTC-E-90 dated August 2015 directs under:

Prevention of Skin Breakdown:

5. All Residents will have a Head to Toe Assessment completed, under the following criteria:
- Within 24 hrs of admission
- Upon returning from hospital
- Upon returning from a leave of absence greater than 24 hours
- Whenever, there is a change in health status that affects skin integrity
14. The Interdisciplinary Skin and Wound Care Team will review documentation, assessments, outcomes, and RAPS/CAPs to develop an individualized Resident Care plan based on Resident's needs and preferences.

Documentation/Monitoring:

4. The Treatment Observation Record (TOR) – Initial Wound Assessment is initiated when a Resident has any open area/wound. One TOR for each open area/wound will be completed. The Treatment Observation Record (TOR) – Initial Wound Assessment will be printed from the electronic documentation and kept in the Treatment binder for each individual Resident wound.
5. The Treatment Observation Record (TOR) – Ongoing Wound Assessment is completed with every dressing change, but minimum every 7 days.

Related to resident #017:

Review of clinical health record for resident #017 indicated the resident was admitted to the home on a specified date with wounds specified areas.

Review of progress notes for resident #017 indicated that on a specified date, the resident was assessed and found to have a new wound. Review of clinical records on electronic record and paper chart indicated resident #017's wound had no indication that assessments were completed using the Head to Toe Assessment form and the Treatment Observation Record (TOR).

Review of care plan for resident #017 indicated that there was no interventions related to wound care. The physiotherapist (PT) updated the care plan on a specified date, directing staff to turn and reposition the resident while in bed. The PT instructions also included transferring the resident to bed after lunch to assist with pressure relief to stage 2 wound.

During an interview with the Wound Care Nurse/RPN #114 it was confirmed, that resident #017 currently has a wound. The Wound care Nurse confirmed that the Head to Toe Assessment and the TOR was not initiated as required. The DOC and RPN #114 both indicated that care plan for resident # 017 should have been updated as soon as the wound was discovered on an the identified date.

Therefore, the home's policy related to skin and wound care was not complied with in the following areas:
-There was no evidence that the Head to Toe Assessment was completed when there was a change in health status that affects skin integrity.
-The TOR was not initiated when resident's wound was assessed and the TOR was not completed with every dressing change or at a minimum every 7 days.
-The care plan was not updated and did not include a focus on wound care based on

resident's needs and preferences. [s. 8. (1) (a),s. 8. (1) (b)]

2. Related to resident #005

Resident #005 was admitted to the home on a specified date and had a wound.

In an interview with RN #104 indicated that resident #005 weekly wound assessments are done by the Wound Care Nurse.

During an interview RPN #114, indicated that wound assessments were completed on a weekly basis and this information can be found in the Treatment binder or in the resident's chart. During a review of the Treatment binder, RPN #114 confirmed that the TOR is used for the documentation of weekly wound assessments. Registered Practical Nurse #114 found no documented evidence of resident #005 wound assessments on the TOR. There was no documentation observed in the TOR on a weekly basis in the period a six week period between the specified dates. Inspector #626 reviewed resident #005 hard copy chart and did not find TOR documentation for the weekly wound assessments between the specific dates and thereafter.

During an interview, the DOC confirmed that the Wound Care Nurse performs weekly wound assessments and documents this information in the progress notes. A review of the progress notes revealed that there was no documentation of the wound assessments found in the progress notes from between the specified dates.

Therefore, the home's policy related to Skin and Wound was not complied with, as the TOR was not completed at minimum on a weekly basis between these specified dates and thereafter. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Related to log #014910-15:

A critical incident report was received by the Director (MOHLTC) for two witnessed incidents of staff to resident abuse towards residents #042 and #043 by PSW #108. The Critical Incident Report (CIR) indicated that PSW #109 reported the incidents to the DOC and the ED that on a specified date, PSW #108 was witnessed being physically abusive towards residents #042 and #043. There were no injuries noted on resident #042 and minor injury to resident #043.

Review of the home's policy "Resident Non-Abuse Ontario" (LP-C-20-ON) (revised September 2014) indicated:

Review of the home's investigation and interview of staff indicated the incident occurred on a specified date and not the date indicated on the CIR. The home's investigation also indicated when the PSW reported the incident on a specified date, the investigation was immediately commenced and the allegation was determined to be founded. The Director was notified on the specified date when the DOC and the ED were aware of the incident.

Review of the home's policy "Resident Non-Abuse Ontario" (LP-C-20-ON) (revised September 2014) indicated:

-On page 4 of 14, any staff member or person who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the Executor Director, or if unavailable, to the most senior Supervisor on shift at that time.
-On page 6 of 14, accurate detailed descriptions of injuries/condition is documented in the resident's chart.

Therefore, the home's investigation and review of the health care records for residents #042 & #043 indicated PSW #109 failed to immediately report the abuse for eight days. The progress notes for resident #043 also had no documented evidence of the incident or to indicate an assessment of the resident was completed as per the home's policy. [s. 20. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229.(4) by not ensuring that all staff participated in the home's infection prevention and control program related to labeling of personal care items.

The following observations were made during the dates of this inspection:

-In a shared bathroom in a resident room, there was an unlabeled bed pan placed in basket under towel dispenser, unlabeled black comb and white toothbrush placed on sink, and a unlabeled white tooth brush placed on basket next to light switch.
-In a share bathroom in a resident room, an unlabeled white urine hat was observed.
-In a shared bathroom in a resident room, an unlabeled urinal was placed on grab bar.
-In a shared bathroom in a resident room, an unlabeled bed pan was placed on top of toilet tank.
-In a shared bathroom in a resident room, an unlabeled green cup containing one unlabeled purple and a white tooth brush was placed on top of the paper towel dispenser.
-In a shared bathroom in a resident room, an unlabeled bed pan was stored in the wall mount basket next to toilet.
-In a shared bathroom in a resident room, an unlabeled pink bed pan was stored on the floor behind toilet.
-In in a shared bathroom in a resident room, an unlabeled green bed pan was stored on top of toilet tank.

Review of the homes Infection Prevention and Control Manual, Routine Practices & Additional Precautions, Policy # IPC-B10 and Equipment Cleaning Policy # IPC-C-10 directs: whenever possible dedicate equipment including bedpans and commodes for single Resident use and label appropriately.

During an interview, the DOC confirmed to the inspector that all personal items should be labeled and stored properly. The DOC is the Infection Control Lead for the home. [s. 229. (4)]

Issued on this 11th day of May, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.